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THE ROLE OF GOVERNMENT IN HEALTH SERVICES*

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Introduction: A Warning On Values

Because attitudes and values inevitably influence not merely an individual's decisions on policy but also his conception of the nature of the problem itself (i.e. his formal analysis) the reader should bear in mind certain of my preconceptions. The most relevant of these to the present discussion are:

First, I regard "government" as one of several possible institutions for achieving given ends. It is as "natural" in contemporary society as any other institution, whether it be the formally uncoordinated actions of individual consumers or producers (the institution of "private enterprise") or an organized profession, or any other voluntary grouping of individuals to achieve ends for themselves or for others. From this perspective, therefore, the concept of government "intervention" or "in-

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terference" has no meaning, nor is "government" thought of as an agency for doing certain things that is utilized only as a "last resort." There are some things that are done better, and some worse, when the largest and most comprehensive unit of organization is involved. Utilizing government to achieve certain ends may entail some undersirable consequences as by-products—just as the use of other institutions may do.

The question to be answered, therefore, is in what areas and aspects of the provision of health services (broadly interpreted) should the largest organizational unit of consumers participate and what should be the nature of its responsibilities. No final answer is offered in this paper (although many of my own predilections will inevitably appear). Rather, the effort has been to lay out the issues and possible ways of grappling with them.

Second, I regard assurance of access to health services at the level that the nation is technically and economically able to provide for all its members an important goal of a democratic society. The importance attached to this objective stems from 1) the obvious significance of good health to the well-being and happiness of each individual, and 2) the bad economic and social consequences to society of the persistence of ill health among its members.

It is important to note that the formulation of this objective does not necessarily imply that health as a human need is necessarily more or less important than other kinds of needs (e.g., for income, or education, or decent housing, or legal service). The task before a group concerned with social policy for health is to spell out the institutional arrangements that would ensure access to the desired type and level of services and to indicate the demand that this provision would be likely to make on the national resources. It is for the community as a whole, and not for any professional group alone, to determine, in the light of the gains to be secured and economic costs involved, whether health has as high or a higher priority than certain other basic needs. At the same time it would seem highly appropriate for medical experts to give guidance to the community as to *priorities within the health field.*

Nor does the belief that access to appropriate health services should be available to all members of the community imply a commitment to any specific mechanism or set of arrangements for achieving the desired result. In particular, the formulation of the objective of access to the desired type and level of health services does not *necessarily* imply

that health services should be provided as a free public service, like education. Such might be the conclusion but one could conceive of a society in which all incomes were sufficiently high to permit individuals to purchase needed services (individually or through insurance) from profit-making providers. And more realistically it is significant that different countries have adopted different approaches to the problem of ensuring adequate health care for their peoples, just as they have in meeting the problem of income maintenance where we find a variety of mechanisms and programs both public and private, rather than a single governmentally operated minimum income guarantee.

Third, I believe that the needed services must be made available to consumers under conditions that, to use Dr. Samuel Standard's word, are "acceptable." Acceptability in my book has two aspects: the conditions under which it is available must not be offensive to individual dignity and self-respect and, insofar as technically possible, the consumer should be able to exercise choices as to the professional serving him.

Consideration of both aspects involves judgments as to other people's values. On the first, I believe it has to be accepted that the vast majority of people in the United States dislike being the recipients of what they conceive to be charity, whether it be offered by an individual (as when a physician adjusts his fees to what he believes to be the income level of his patient) or by a philanthropic organization or by a government (as when any specific service is available only to persons who fall below some more or less explicitly defined measure of need). The strength of this feeling is most clearly evident in the widespread popularity of social insurance, here and in almost all major countries, for this is a mechanism for permitting the insured individual to claim benefits as a right and to feel that he has contributed toward their cost to the extent his means permit. The use of the word "claim" throws some light on what underlies this antipathy to charity, public or private. For it means that the individual who is a *claimant* is to a significant degree freed from dependence on the discretion of others (whether individuals or administrators of a program). He is no longer an "applicant." Thus the dislike of acceptance of charity is one aspect of the desire for freedom.

The desirable degree of freedom to choose the professional who will render service is more difficult to describe in general terms. Pre-

sumably it relates only to physicians, surgeons, dentists, and others rendering intimate personal service. For it should be noted that in vast areas of medical care freedom to select the individual practitioner does not even come into question. In hospitals patients cannot select their nurses (even with private-duty nurses it is a limited freedom). Nor do they select the interne or resident, and certainly not the renderers of auxiliary services (anesthesia, x rays and many other treatments). In outpatient and emergency facilities there is equally no free choice of doctor, and yet the use of these sources of medical care appear to be becoming more widespread and popular. And with the growth of "team" medicine it would seem that the freedom of the patient to select his individual professionals will be even more restricted, and that the values of his attempting to do so will be even more questionable.

Even in regard to the individual general practitioner, the surgeon, and the dentist, freedom of choice is severely circumscribed by the geographical availability of these professionals and by the incomes of those who seek care in relation to what they believe to be the charges of the professional.

There is perhaps no more useful service that a group of medical leaders could render toward a more rational consideration of the issues involved in the provision of health services than to clarify the meaning of the concept "freedom of choice of physician, etc."

Fourth, as a professional person I have strong feelings about the importance of exclusive professional control of strictly professional matters. Differences of opinion on this topic seem to stem largely from different definitions of what is a "professional matter," and my own concept is undoubtedly narrower than that of the American Medical Association. Obviously it includes definition and evaluation of competence and quality of performance of professionals when only the profession can and should be the judge. I do not think it extends to arrangements for the organization and financing of health services. A profession would certainly be expected to evaluate different arrangements (actual or proposed) from the point of view of whether or not they are conducive to the rendering of high-quality service and to take a position accordingly. But I believe that no profession can set itself up as the arbiter of policy. In a democracy it is the community as a whole that in the last resort must determine policy—even if this

means sacrificing maximum professional performance to some other objective.

Finally, it is probably hardly necessary to remind the reader that I am not a *medical* professional—what follows is written from the point of view of a consumer of health services who happens also to be a professional economist.

The Extent of Government Involvement in the United States Today

Even in the United States, where the role of government is probably less prominent than in almost all other countries of a comparable level of social and economic development, governments—federal, state, and local—are nevertheless heavily involved in the complex of arrangements for health care.

First, government already provides a sizable proportion of the total funds devoted to health care in the United States. Public expenditures accounted for 25.2 per cent of all such expenditures, public, private consumers, and philanthropy, which amounted to approximately $32.9 billions in 1962-63. For personal health care alone (excluding such items as research, construction, etc.) the public share was 21.3 per cent of a total of $28.6 billions. And, with the exception of the war and immediate postwar years, these proportions have sharply increased over the last 30 years. (The corresponding percentages in 1928-29 were 14.1 and 9.5[1]).

There has also been a shift in the respective roles of the federal government and the states. The former has been steadily increasing in importance. Of all *public* expenditures for health and medical care in 1934-35 the federal government contributed only 20.1 per cent; the state and local share was 79.9 per cent. By 1962-63 the federal share exactly equaled that of the states and localities.

The part played by government differs considerably in the different branches or areas of health care. As indicated above, governmental programs meet only a little over 20 per cent of the expenditures for personal health care (hospitals and medical institutional care, physicians, and other professional services and drugs). The major programs for direct care are those provided and operated by the federal government for the armed forces and veterans, the special disease hospitals (mainly mental but some tuberculosis) financed and operated usually by the states and medical-care programs for public assistance or other

needy groups administered by states and/or localities but for which the federal government provides somewhat more than half the funds. Expenditures on other publicly financed programs, such as Medicare (the official name of the program of health care of dependents of those in the armed forces) and the health insurance program for federal employees (financed in part by the federal government but operated by private profit and nonprofit insurance agencies), maternal- and child-health services, medical care under workmen's compensation and vocational rehabilitation legislation, all have increased over the same period.

On the other hand, government provides almost two thirds of the funds devoted to medical and health-related research. Of an estimated total national expenditure for this purpose of $1.55 billions in 1962-63 government contributed no less than $1.018 billions (federal, $973 millions; state and local, $45 millions). Private expenditures accounted for only $532 millions (of which industry contributed $390 and philanthropy $142 millions).*

In the construction of medical facilities the public share is less than that of the private sector ($632.5 million as against an estimated $850 from private sources, including philanthropy).

Expenditures alone fail to give a full picture of the degree of governmental involvement in the provision of health care. For in general, government as a spender is unlikely to behave as an individual consumer who can exert little direct influence on the price charged, the quality of the care or the organizational arrangements for its provision (see below). Although there still appear to be some local public assistance authorities who foot the bill for medical care provided their clients without any concern at all for these matters, most governments in buying or subsidizing services lay down certain standards or requirements intended directly to affect prices of services, or quality or (less frequently) organization. And there may be considerable difference, too, in the total impact of any given volume of expenditures according to whether government acts through other agencies (philanthropic or profit-making) or whether it directly operates medical-care programs.

*See Merriam, I. C.,[1] p. 11. It should be noted these figures exclude, for government, support of such activities as research training or capital outlays for research facilities and, for private, the research expenditures by pharmaceutical, medical supply, and medical electronic industries (because their cost is presumably included in the price for the product).

The Problems As Viewed By Consumers (Including Would-Be Consumers)

From the viewpoint of the consumer the current arrangements for the provision of health services have many shortcomings.

Financial Restrictions on Access to Needed Health Services

Although the health services have become more scientifically based and science has made possible more effective care, this progress has resulted in raising the costs of care to the individual or family. At the same time the population's expectations of the health service have increased. They believe that high levels of health are possible and their demand for health services has expanded correspondingly.

But the better service that is demanded (and in many cases supplied) costs money and, as incomes in general have not risen as fast as the costs of health care, the proportion of disposable personal income (income received by individuals less direct taxes paid by them) devoted to private consumer health expenditures has steadily increased. In 1948 these expenditures amounted to 4 per cent of disposable personal income; by 1962 the percentage had risen to 5.7. In constant (1962) prices private consumers increased their per capita expenditures on medical care from $86.40 in 1948 to $119.44 in this same period.[2]

The rising costs and high level of care demanded have given rise to two acute problems: 1) because of their low levels of income, some segments of the population are unable to purchase needed care from their own resources at any time; and 2) because of the unequal incidence of illness and disability and the very high costs of some types of care, some individuals or families are either unable to meet the costs of some types of care, or do so only by exhausting their savings and/or contracting heavy debts.

The Role of the Private Sector

The private sector of the economy has reacted to this situation in various ways:

Adjustment of Charges by the Purveyor of Service

Some suppliers of medical services (notably the medical professions in the narrower sense) have adjusted their charges to what they know or believe to be the economic resources of their patients. But to the consumer this response has serious shortcomings:

1) Although the medical profession does not seem aware of this, most patients find this form of private charity highly offensive and either do not seek care when they should, or avoid suppliers or forms of care believed to be "expensive," or accept the charity with resentment (which is hardly conducive to good doctor-patient relationships).

2) To many members of the medical profession this introduction of financial bargaining into the patient relationship is distasteful. Furthermore, the inability of a patient to meet even the medically "reasonable" costs of various forms of treatment may deter a physician from prescribing what, as a medical man, he knows would be desirable. It is significant that in systems where the financing of medical care is no longer a matter for negotiation between individual doctor and individual patient, the favorable comment most frequently made by the participating physicians is that it is then possible to prescribe the medically indicated treatment without having to consider the patient's ability to pay for it.

Furthermore, there is a limit to the extent to which the physician can supply service to some patients at zero or below-market price, and the necessity to recoup himself by above-market charges to wealthier patients may meet resistance from them (even if he does not practice in a low-income neighborhood where rich patients are rare).

3) Adjustment of charges by providers of service applies to part only of the consumers' medical care dollar (36.5 per cent if dentists are also included). Adjustment of charges by the provider of service (or supplies) scarcely occurs in the sale of drugs, which accounts for 18.9 per cent of consumer medical expenditure. And in hospital service, which commands 27.8 per cent of the consumers' dollar, this type of adjustment appears to have become increasingly rare as hospital insurance has grown and as hospitals have exploited the possibilities of accepting needy patients via the public welfare system and charging at least part of the costs to some public agency.

Development of Private Prepayment or Insurance

A second type of adjustment in the private sector has taken the form of voluntary organization (initiated by consumers or, in the United States, more usually by producers) to develop systems of prepayment, most generally through the insurance mechanism. This approach has

seen a dramatic expansion in the United States in the last thirty years. Insurance plans (Blue Cross and Blue Shield, commercial insurance, and the independent plans providing specified health services on a group prepayment, risk-spreading basis) met 29.6 per cent of the total personal health expenditure in 1962 (as against only 11.2 per cent in 1948).*

From the consumers' standpoint, however, insurance, profit or nonprofit, has certain disadvantages:

1) Voluntary insurance cannot be the answer for those consumers whose incomes are too low in any case to furnish the minimum requirements of decent living in the mid-20th century.

Thus, although three fourths of the population in the United States have some form of health-insurance coverage, it is significant that insurance has failed to make a serious impact on certain low-income groups such as migrants, low-income farmers, and the aged,** even though the low-income groups typically spend an above-average proportion of their incomes on medical care.†

Furthermore, much of the great expansion of coverage in recent years has occurred in connection with the contract of employment. Those who are effectively out of the labor market are unlikely to be covered by this mechanism.

Efforts have been made by nonprofit concerns to expand the availability of insurance by setting community rates, averaging the costs of a high-risk group (e.g. the aged) over the entire group, and the like. But to do so necessitates raising premiums for the covered group and exposes segments of that group to the competitive appeal of commercial insurance companies who, by experience rating and selectivity of groups accepted, can offer more favorable terms to "good" risks. Thus it is not surprising that in recent years the commercial insurance companies have taken over a larger share of the total of voluntary health insurance, or that some of the nonprofit systems, e.g. Blue Cross in the

*The proportion varies greatly in the different branches of health care. Insurance payments in 1962 met 65.6 per cent of hospital expenditures and only 33.6 per cent of costs of physicians' services.[3]

**For an analysis of coverage by size of family income and size of family, see Lawrence and Fuchsberg.[4]

†In 1960-61, all urban families spent 6.6 per cent of their incomes on medical care. Families with annual money incomes of under $2000 spent 8.2 per cent, those with incomes of $2000 to $2999 spent 7.3 per cent, and those with $4000 and more spent 6.4 per cent.[5]

‡In 1962 insurance companies accounted for 52.4 per cent of total income of these plans and 47.8 per cent of all benefit expenditures. The corresponding proportions in 1948 were 48.8 per cent and 37.6 per cent.[6]

city of New York, are departing from community rating.

The insurance industry in recent years has been making herculean efforts to meet the problem for one low-income group—the aged. Yet success has been limited, and some of the 65-plus plans are experiencing financial problems.

2) Even when the purchase of insurance is within the means of a consumer and he can find a plan to accept him, reliance on voluntary insurance is still an inadequate answer. For unless the scope of services provided for is wide, and unless the benefits assured take the form of service benefits, the consumer may still find himself carrying costs he regards as onerous.

Insurance is today still largely concentrated on the costs of acute care in hospitals and on surgical procedures; thus sizeable costs are not covered. The typical commercial insurance policy operates on the indemnity system and as, in general, the reimbursable sums are modest in relation to normal professional charges, the consumer may have a sizeable differential to meet, even if, despite consumer suspicions to the contrary, the provider of medical services does not deliberately increase his charges when he knows that the patient carries insurance.

Even under the most widespread nonprofit service plans, the Blue Cross and Blue Shield, the consumer is not completely covered. There are limits on the per diem reimbursement for, e.g., room accommodation; and the shortage of semiprivate rooms in many hospitals means that the patient must meet the excess costs of single occupancy. (Here again consumers suspect that the providers of service on occasion have taken advantage of the availability of some insurance to make the patient buy a higher quality—and price—accommodation than he would wish.) Only very low-income receivers covered by Blue Shield plans are protected against additional charges by physicians over and above the amount reimbursed by the plan.

More recent efforts by private enterprise to meet the problem of "catastrophic" or unduly heavy medical expenses have undoubtedly been a real boon to the middle- and upper-income groups—until now. But it seems likely that an inherent feature of major medical insurance plans will, in the not-so-long run, limit and perhaps even reverse their rapid growth. This is the upward pressure on costs exerted by a system that exercises no control on the prices charged, and services prescribed,

by suppliers of services from whom the brake of concern about the financial burden on their patients has been largely removed. The frequency with which major medical plans are finding it necessary to limit benefits or, more usually, to raise premiums, may well make this form of insurance financially unavailable to the income groups that need it most.

3) Finally, to the consumer, solution of the problem of financing medical care through the voluntary insurance mechanism carries with it certain costs. In 1962 the operating costs of all plans (meaning thereby the percentage that was retained for acquisition and other administrative expenses, premium taxes, additions to reserves and profits) amounted to 14 per cent of all payments for health insurance. The costs varied greatly for the different types of carrier.[7]

	Per cent
Blue Cross-Blue Shield total	7.2
Blue Cross	5.7
Blue Shield	11.0
Insurance companies total	20.0
Group insurance	9.4
Individual	42.7
Other plans	9.2

The Role of Government

Far and away the most common type of governmental involvement (other than in the area of general "public health services" and of licensing, which will be dealt with below) is in regard to the financial inability of some groups to purchase needed care. Indeed, the history of most developed countries suggests that this problem has almost everywhere been the major stimulus to governmental involvement, and that public action in regard to, e.g., the adequacy of facilities and personnel, the quality of care and the organizational arrangements for the provision of health services, and the economical use of resources has occurred primarily as a result of public involvement in the financing of personal health services.

In this latter area, governmental action has taken many forms:

Meeting the Costs of Care for Persons Satisfying a Standard of Need

This is the earliest type of public action to deal with the financial

barriers to receipt of needed health services, and it is still the most widespread, although its medical importance in a country's total arrangements for the provision of medical care varies with the coverage of other governmental programs. In countries where medical care is freely available to all (e.g., in the Soviet Union and Great Britain) it plays no role. But even countries with extensive social insurance systems have found it necessary to provide, through public action, for the medical needs of the needy noninsured. In the United States this necessity accounts for approximately one seventh of all government expenditures for health and medical services.

Typically, needs-test medical care is administered by the public assistance authorities, who have adopted a variety of methods. In some cases the care is directly provided by the government itself, through a salaried physician or a governmentally owned and operated hospital. Sometimes it is purchased from organized suppliers (a contract may be made with a group of physicians, or hospital insurance may be purchased through, e.g., Blue Cross). Sometimes the authority will merely pay the bills for services rendered to its clients, either meeting full cost or a fraction thereof, and this may be done either by direct payment to the supplier (the so-called vendor payment in public assistance programs in the United States) or (less frequently) by including an item for medical care in the budgets of public assistance recipients, who are then supposed to pay their own medical bills.

As a method of meeting the financial problems of individuals, means-test medical care has both advantages and disadvantages. As compared with all other methods (other than the universal public-service programs) it has the advantage of being, *in principle*, all-inclusive. It also meets the objections of those who ask why free medical care should be available to people who can easily afford to pay for it from their own resources.

But the all-inclusive potential is in practice limited by the fact that, except in Great Britain and New Zealand, which in any case have comprehensive health programs, public assistance is a locally administered program, and even in the United States it is a state, rather than a joint responsibility in only about a dozen states and, in five of these, state responsibility does not extend to general assistance. The standards of eligibility and the nature and extent of care provided reflect local

attitudes toward "the poor" as such, but even more the widely varying economic status of the local communities (and even states).

Thus there is great variation in both recipient rates and extent of care available under such systems,* and the problem is intensified because it is primarily the poorest and most depressed areas, where fiscal resources are least, which are likely to have the largest proportion of needy people.

Larger units of government have often been invoked to deal with the problem of unequal fiscal resources through the system of grants-in-aid (cf. the public assistance grants in the United States or the Kerr-Mills grant program). But because it has generally been thought necessary to require the recipient unit of government to carry some fraction of the costs as one method of ensuring responsible administration,† the grant-in-aid still fails to overcome the financial problem faced by the poorest communities. And no grant-in-aid system has been able to overcome the obstacle to provision of adequate services that stems from local attitudes and values.‡

An even more serious disadvantage of means-test medical care is the fact that most people appear to find it psychologically offensive. It is significant that although some such program has been in effect since early times in most European and English-speaking countries, public pressure has led to the development of a wide variety of other arrangements (to be discussed below) to enable people to secure medical care without having to utilize "means-test medicine." In the United States efforts have recently been made, through the Kerr-Mills legislation, to create a "glorified" means-test medical-care program for the aged, but the evidence suggests that this is no more acceptable to those who found the means-test approach offensive, and that many who could benefit from it prefer not to do so. We do not know whether the same dislike of the program would prevail if 1) the test were administered by some authority other than the one administering public assistance, and 2) if

*Average vendor payments per recipient for medical care to old age assistance recipients in December 1963 ranged from $73.46 in Wisconsin and $69.64 in Minnesota to $0.46 in Montana and $1.48 in Mississippi, the national average being $15.44. Among the states that have adopted programs of medical assistance for the aged average expenditures per recipient in the same month ranged from $439.00 in Illinois and $357.12 in Vermont, to $21.53 in Kentucky and $21.90 in West Virginia, the average being $201.20.[8]

†In the most liberal of grant-in-aid programs in the United States—the Kerr-Mills plan, which sets no limits to the total expenditures in which the federal government will share, the federal proportion ranges from 50 to 80 per cent.

‡Efforts to do so by requiring as a condition of receipt of a grant the provision of some minimum specified services (as under the Kerr-Mills law) does not achieve the desired result if a state simply decides that, on such conditions, it does not wish to accept the grant offer.

eligibility were liberalized so as to eliminate the relatives' responsibility principle and to raise the income limit, which is today only slightly above the public assistance standard in most cases. But it should be noted that the more liberal the income test, the more such a program would approach a free public medical service.

A third disadvantage of means-test medical care is its impact on the nature and quality of the care available. When something is given as a concession the recipient typically has few rights, including the right to complain. Involvement with questions of quality and appropriateness of care is relatively rare on the part of the public assistance authorities. Given the prevailing attitude toward "the poor" a system of medical care thought of as "for the poor" is unlikely to be held to the same standards as apply to care paid for by the recipient, or available to the entire population as a public service (such as education). It is significant that many observers of the British Health Service attribute the many improvements, from the patient's point of view, that have been effected since 1948, to the fact that for the first time the middle classes are the users of public medical care and are demanding the kind of standards and quality to which they have been accustomed. It is no longer a service "for the poor only."

Granting Subsidies to Institutions Organized by Private Individuals to Lighten or Remove the Financial Burden for Themselves or Others

Governments have utilized the subsidy principle in various ways:

Subsidies to Consumer-Organized Prepayment Systems. In a number of European countries during the 19th century groups of workers, trade unions, or citizens of a given community had organized mutual benefit or sickness funds to pay for the medical care of their members. An early form of public action was the encouragement of such activity by the granting of subsidies to permit these organizations to pay for a wider range of service, or to enroll less affluent members, or to equalize financial burdens as between rich and poor, healthy and unhealthy, communities. Despite governmental encouragement and growing subsidies, these organizations failed to attain acceptable coverage or to meet the costs of a full range of health services, and one country after another has replaced the subsidized voluntary system by compulsory health insurance as the only way to ensure appropriate coverage and in

view of the fact that even the subsidy system involved a high degree of governmental control.*

Subsidies Toward the Purchase of Private Insurance (Nonprofit or Commercial). Proposals for this type of government action have been under discussion in the United States in recent years, as an alternative to a public compulsory hospitalization insurance program for the aged. In fact, relatively few countries or states appear to have adopted this approach.

Australia is a notable exception.† People insure with a private insurance organization for specified benefits. For medical care, in addition to their insurance benefit they receive a Commonwealth Benefit from the federal government on the basis of a fee-for-service schedule. For hospitalization, the patient receives, in addition to his private insurance benefit, two subsidies from the government: a daily payment (8/—) paid to every patient insured or not, plus a second daily payment of 12/— if he is insured.

Despite the stimulus given to insurance and extensive advertising, the scheme after 13 years had enrolled only about 70 per cent of the population. And for those covered not all costs are met. Medical men are free to charge whatever they wish, and the total refund (insurance plus the government benefit) has represented between 63 and 64 per cent of medical fees paid in recent years. For hospital care the freedom of the insured person to select the amount of coverage he will purchase makes generalization more difficult, but it is believed that even with the substantial public subsidy, many insured individuals are not fully protected.

It is important to note, too, that this program is buttressed by other public medical programs. A separate pharmaceutical benefits system, universally available, provides for reimbursement of the cost of drugs in excess of 5/— per prescription. There is also a program of special daily subsidies for nursing and convalescent homes, whose long-stay inmates typically have exhausted their insurance benefits. And there is a Pensioner Medical Service which provides free medical care to pensioners and their dependents under a special means test, the physicians being

*As public financial participation increased it was accompanied by increasingly specific standards which extended beyond safeguards for accountability to the minimum types of services to be insured against, or the membership eligibility conditions.

†For a convenient account of the Australian system, see *The Lancet,* April 20 and 27, 1963.[9] Alberta, in 1963, also introduced a system of subsidies toward the purchase of comprehensive medical benefits payable, however, on the basis of an income test.

reimbursed by the government.

Subsidies to Philanthropy. In most countries organized philanthropy has played a more or less important role in the provision of health services. The church in earlier days in Europe and, more recently, private sectarian and nonsectarian charitable groups, have built and operated hospitals, financed health services such as visiting nurse services, financed treatment and research for specific types of illness (polio, mental retardation, cancer, etc.). In some countries, such as the United States, government has encouraged their development by granting subsidies in the form of tax concessions, both to the private individual who contributes to them and to the organized institution or agency that operates as a nonprofit corporation.

In fact, despite this substantial encouragement, the role of philanthropy appears to be diminishing (except perhaps in hospital construcstruction). Furthermore, as a method of overcoming the general problem of the financial barrier to access to medical health services, philanthropy has several disadvantages. It tends to be spotty in coverage, concentrating on specific illnesses that have a dramatic public appeal but not very broad incidence. Where, as in the case of the private general hospital, no such "disease selectivity" prevails in principle, it may be replaced by other types of selectivity. In a publicly operated service the potential clients are defined by law, the public agency must accept all who fulfill the legal eligibility conditions, even if it means lowering standards of care because of limited resources, and it is held responsible when eligible persons are not served. But the subsidized private agency is not so constrained. It can pick and choose among those who wish to use its services and it may reject some either because of a desire to maintain high standards in the face of limited income or because the patients may be regarded as inappropriate subjects for research or teaching.

The subsidized private agency thus tends to encourage the development of two systems of care and, the higher the quality of care rendered by the protected voluntary system, the more this is likely to be true. It is interesting to note that precisely the same situation prevails in social work, another service industry characterized by considerable reliance on private philanthrophy, especially in the North and the East. Here we find a sharp division: high-standard voluntary agencies attracting the cream of the professionals interested in high-quality practice

and research, serving a very limited clientele who are selected by reference to whether their diagnosed needs fit the agencies' own defined purposes and who are to an increasing degree middle class. On the other hand, we find the public welfare agencies swamped with heavy case loads, many of them among the most difficult and needy cases and, because of the necessity to ration service not by turning people away, but by giving limited or perfunctory service to each, unable to attract well-trained professionals.

Subsidies to Individual Consumers. In the United States, government has been invoked to assist the individual in meeting his medical bills by granting income-tax deductions for medical expenditures.* This approach has serious shortcomings. On the one hand, it gives no assistance at all to the person whose income and other claimable deductions place him below the taxable income level. Thus it fails to solve the problem for some groups for whom it is most acute (e.g., the aged, the poor, and large families). And on the other hand it gives most help to those who need it least, namely, the very rich. For the dollar value of a deduction in a progressive tax system is greatest to the man whose income is taxed at the highest marginal rate. A tax *credit* would avoid this disadvantage, but the first one would still remain.

Compulsory Insurance

Apart from public assistance, this is far and away the most common governmental method of attacking the financial obstacle to receipt of health services. Individuals and, almost universally in the case of wage-earners, their employers, are required to pay ear-marked taxes (euphemistically and for historical reasons called contributions) in return for which they (and usually their families) are entitled to receive care free or on a subsidized basis. In many cases the government also contributes from general revenues to the health insurance fund.

Essentially the same approach is found in New Zealand where, although "social insurance contributions" are not found, income-receivers are required to pay an additional, ear-marked income tax in return for which they are entitled to certain types of health services. However here, as in Norway and Sweden, where a universal compulsory health insurance system prevails, the right to receive medical

*In the United States abolition of this concession would, it is estimated, increase federal revenues by $1.16 billions (based on 1963 incomes at 1965 tax rates). It is thus a sizeable subsidy. All but $200 million of this is claimed by persons with adjusted gross incomes in excess of $5000.

care on a free or subsidized basis is not conditional on having in fact paid the required contributions or taxes.

Within this general framework there is great variation among the different systems.

Coverage of the Programs. Among the insurance systems, properly so-called (i.e. excluding the Norwegian, Swedish, and New Zealand systems), none provides for universal coverage. The insurance concept implies that entitlement to benefits is established by the prior payment of the taxes for some specified period. Individuals who have no incomes to tax or who are not employed, or whose conditions of employment are likely to make the technical tax collection problem very difficult, are either excluded by intent or in fact (e.g., migrant workers and certain types of agricultural and domestic workers). Certain groups are sometimes covered by separate and somewhat differently financed plans (e.g., agricultural employees, farmers, and the self-employed), and sometimes provision is made for voluntary insurance. Family members are usually covered as dependents of the insured person. Coverage of Western insurance systems ranges between 16.3 per cent of the population (Greece) or 17 per cent (Portugal) to 82.4 per cent (West Germany), the most usual percentage being between 45 and 55.[10]

Sometimes there are income limits to coverage, those with wages or incomes above a certain limit being excluded.

Range of Health Benefits Provided. Although the tendency everywhere is for wider coverage, most systems limit in some degree the types or the duration of care. The British system (1911-1948) was essentially limited to general practitioner services. In some systems, especially if the country is provided with a free or otherwise financed hospital system, hospitalization may be excluded. Dental benefits are not always available, or they are restricted to certain population groups, such as children and expectant mothers. Pharmaceuticals, sometimes on a restricted basis, are usually included among the benefits. Prostheses may or may not be provided.

In some cases, as in Canada, social insurance has been applied only in regard to hospitalization, although the recent Royal Commission report recommends its extension to cover all medical services.[11]

Utilization of the Reimbursement or Service Principle. Some systems reimburse the patient (or the supplier of the services) with some fraction of the costs incurred, or with full cost, based upon some legally

specified tariff. This is the case, for example, in Sweden, Norway, New Zealand, Australia, and France. Others make the defined services freely available to the insured person and pay the suppliers directly (according to a variety of principles and methods to be referred to below), so that the patient has no financial dealings of any kind with the vendor. This was the policy in Great Britain from 1911 to 1948 under the health insurance system, and it prevails today in Italy and Germany (except for some drugs for family members). In some cases this system is modified by the imposition of a (usually nominal) charge for certain goods or services (e.g., for drugs, dentures, eyeglasses, etc.).

As a technique for removing the financial barrier it is evident that, to the consumer, the service approach is the more effective. For unless the vendors agree not to charge more than the charges specified in the tariff, the consumer still has to meet the difference between what is reimbursed and what the professional supplier charges, and this may be considerable.* And unless reimbursement is at the 100 per cent rate he will always have to bear some of the cost. This greatly limits the effectiveness of the program to the low-income receiver and necessitates the utilization of some additional machinery (usually on a means-test basis) if such people are to secure the care they need. The advantage claimed for partial reimbursement only is, of course, that it acts as a brake on irresponsible use of the service—to which it has been objected that it may equally deter individuals from seeking care until a condition becomes acute and thus works against early detection and possible prevention.

Methods of Supplying Health Care. Most health insurance systems involve a minimum of intervention in the existing organizational arrangements for providing medical care. The patient uses such doctors or hospitals or clinics as he chooses among those available in his community and willing to participate in the program, and the only difference is in the financial realm. The insurance system usually has little concern with quality of care except to provide safeguards against gross

*Thus in France, in the general scheme, where in principle the beneficiary is expected to pay 20 per cent of total expenses (except for long-duration sicknesses and certain expensive treatments) the beneficiaries' actual share is closer to 50 per cent because of the difference between the reimbursment tariff and the actual fees charged by doctors, dentists, and midwives.[12] In Norway the system reimburses 60 to 65 per cent of the first and second visit to a physician, within the limits set by an official tariff. For severe illnesses 70 per cent is reimbursed. In Sweden 75 per cent of the physician's fee up to the legal tariff is reimbursed, while 50 per cent of the cost of drugs in excess of a minimum sum are reimbursed. There is some evidence that because of the shortage of supply of physicians it is possible for practitioners to charge in excess of the tariff, and it has been estimated that in Stockholm in 1958 the insurance system reimbursements amounted to only about 60 per cent of the charges.

incompetence and provision of grievance machinery for dissatisfied patients, and none at all with the adequacy and distribution of personnel and facilities. On the other hand, there are likely to be efforts to control quality of care as it affects cost (see below). Essentially the position is that if an individual can secure medical attention the system will relieve him of some or all of the costs.

Some systems, however, provide the legally specified services directly, though these usually take the form of special institutions such as convalescent homes, sanatoria, and the like. But in Austria the insured person must seek care from doctors under contract in health establishments (dispensaries and hospitals) belonging to the several insurance institutions.

Methods of Remunerating Professional Suppliers. Because most compulsory insurance systems purchase care from professionals in private practice or from public or private hospitals and similar institutions the financial arrangements have assumed great importance—unfortunately often to the exclusion or neglect of other aspects of governmental involvement in the provision of health services.

For professional services the insurance fund typically negotiates methods of payment with representatives of the medical profession (or with a group representing the doctors who are willing to participate in the program). A wide variety of payment systems is to be found, many of which have been discussed by Dr. Abel-Smith[13] and will not be repeated here. (See also W. Glasser[14] and J. Hogarth.[15]) With hospitals or clinics the financial arrangements may be negotiated either with the institutions as a group or individually (in the latter case usually within the limits of a scale set by the central authority).

In the case of both individual practitioners and institutions these negotiations have often given rise to sharp differences of opinion between the suppliers of service and the social insurance authority.[16, 17] (Because the essential problems are the same, similar differences have arisen in the case of a national health service.)

Methods of Financing. Although all social insurance systems collect taxes or contributions from potential beneficiaries (and/or their employers) the extent to which these funds meet all costs of the system varies from country to country. Not infrequently the contributions are supplemented by funds from the general revenues. A few countries, however, provide for no public subsidy to the general scheme although

the state may contribute funds to schemes for special groups (such as miners in Austria, or students in West Germany, the severely disabled and war survivors in France, etc.).

Care must be taken in generalizing about the extent of contributions from the general taxpayer to allow for the fact that in some countries important types of health services are directly provided by government outside the insurance system. Thus in Sweden, in addition to certain subsidies to the social insurance system itself, much medical care is furnished through the hospital system, for which the health insurance funds pay only a nominal sum, the remainder being financed by the owners and operators of the hospitals (90 per cent of them being public authorities in Sweden).

General Limits to the Social Insurance Approach. Some of the achievements and shortcomings of the compulsory insurance approach in regard to quality of care and use of resources will be dealt with in subsequent pages. But as a method of removing the financial barrier to receipt of health services it should be noted that social insurance has two serious disadvantages. First, unless it takes the form (as in New Zealand, Norway, or Sweden) of a universally applicable requirement to "insure" or to pay taxes coupled with arrangements for blanketing-in (usually at the expense of the general taxpayer) groups not, in fact, paying the tax or contribution, it fails to provide universal coverage. Second, as a method of financing it is distinctly regressive. The worker's share is at best a proportionate tax with no deductions or exemptions, and the employer's share is generally held to be in large measure shiftable via wages or prices. Whether or not this is a serious disadvantage depends on the progressive or nonprogressive character of other parts of the tax structure, and the presence or absence of some subsidy from general revenues to the health insurance system. In the United States, where all other social insurance programs are financed wholly from wage and/or payroll taxes, this might be a serious consideration although, even so, it could be argued that if the insurance approach is to be utilized social insurance has at least the advantage, as compared with private insurance, of assessing charges that are in some measure porportionate to income.

Direct Provision of Some or All Types of Health Services for Some or All Members of the Community

This kind of governmental responsibility, which involves employing

professionals and owning and operating facilities, has been accepted in varying degrees:

For Some Types of Illness. Thus in the United States, as in many other countries, institutional care for those with mental illness, or tuberculosis, or leprosy, has typically been provided in public hospitals —perhaps because such people were regarded as constituting a danger to the community and public action was regarded as a form of police action or "public health" activity.

For Some Types of Services. Apart from environmental health services the most usual type of health service undertaken by government is hospitalization. Thus in Norway and Sweden hospital care is an almost free service universally available in publicly owned and operated hospitals.

Comprehensive Care for Some Groups. In the United States, government has sole responsibility for ensuring receipt of needed health services for members of the army, for veterans with service-connected disabilities and, to an increasing degree, especially for hospitalization, for veterans with nonservice-connected disabilities. This kind of publicly provided care is also available to members of Congress, presidents, and other important officials.

Comprehensive Care for the Entire Population. Outside the Communist countries, Great Britain is the only major country to expand the role of government to embrace acceptance of full responsibility for ensuring free medical care (subject only to certain modest charges for dentures, eyeglasses and drugs) and needed health services to all members of the community, regardless of the payment of prior contributions or the passage of a test of need, or even of citizenship. It owns and operates practically all facilities and employs 95 per cent of the professionals. Although a small number of institutions remain in private hands for the utilization of those who do not wish to avail themselves of the public facilities, and although general practitioners, specialists, and dentists are permitted to accept private patients, only about 5 per cent of health care is in fact received "outside the service." This approach is, of course, the only certain and complete answer to the problem of the financial barrier to receipt of medical care. And it is an answer that does not involve either the passage of a needs test* or the

*A relatively few individuals who find the payment of the charges for drugs, etc. a hardship can secure reimbursement from the National Assistance Board on passage of the Board's test of need.

organization of health services into two systems: one for "the poor" and one for the rich. It is equally obvious that the comprehensiveness and quality of care available depends on the extent to which government assures an adequate supply and distribution of personnel and facilities and on other factors affecting quality of care (see below). At the very least the national health-service approach involves a rationing of available facilities and personnel by some principle other than ability to pay.

Difficulties of Securing High-Quality and Appropriate Care for Other than Financial Reasons

Despite the great advances in medical technology, there is a sizeable gap between the quality and level of health care many people receive and the care that is technically possible. A major complaint of consumers is indeed that even when financial considerations are not a major obstacle they are not always or everywhere able to secure high-quality care. This is due to several factors:

Inadequacies in the Supply of Personnel Facilities in General or in Certain Geographical Areas

There is considerable difference of opinion as to the adequacy of the total supply of medical personnel and facilities in the United States.* Although the number of physicians per 100,000 population has been declining (there was a slight increase after 1957) it is held that this has been largely offset by rising productivity, including both greater technical efficiency and a higher ratio of patients actually cared for per physician. However, the latter may merely indicate an adaptation to scarcity. Certainly to the consumer the shorter time spent with the doctor, the declining frequency of home visits, the necessity to staff some hospitals with doctors trained abroad (some of dubious competence), and the fact that physicians' incomes have increased more sharply than those of other professional groups—all these factors indicate scarcity relative to demand and a deficiency in the output of medical graduates. Whatever views may be held as to the adequacy of the total supply of personnel and facilities, there is no gainsaying the

*The various viewpoints and evidence are conveniently summarized in Chapter 5 of Seymour Harris' *Economics of American Medicine*. The physician ratio in the United States was reported by the Bane Committee as being 132.7 per 100,000 population in 1959. For the same year, the World Health Organization of the United Nations, using as its measure population per physician reported a somewhat lower ratio, namely 790 population per physician (Bane figure would yield 754). Comparable figures for other countries (population per physician ratio) in 1959 were, New Zealand 700, Germany 730, Australia 860, Norway 900, Canada 920, England and Wales 960, Sweden 1,100, Finland 1,600.[19]

fact that some parts of the country are more adequately supplied than others, and conversely.*

The Role of the Private Sector

The principles on which the private sector operates would suggest that the free market would ensure a supply commensurate with demand. Scarcity would lead to high prices for the scarce service or facility and this, in turn, would stimulate a transfer of resources to the items in short supply. In the health services this operates only to a limited degree.

1) The high cost of training for professional service, which limits access to professional schools, narrows the area of recruitment. The lower income groups are in no position to respond to the high market value of professional service and, in fact, are very poorly represented among practitioners.

2) Entry to the professions is controlled by organized professions which, for otherwise good and understandable reasons, are granted a legal monopoly. Although formally their authority relates only to the determination of professional competence it can, in effect, extend to the supply of training facilities (as when an influential medical association opposes the creation of additional medical schools). Effective control by a private organization of entry to a profession can operate well or badly to ensure an appropriate total supply, depending on whether the profession concerned places predominant emphasis on the individual economic interest of its members (which are of course served by scarcity) or on the well-being and needs of the community. (To the nonmedical observer there seems to be a sharp difference between, e.g. the medical and the nursing professions in the United States in this respect.)

Private philanthropy has also played a role in the problem of supply and distribution of health services. Through scholarships and other training grants and by supplying funds for the construction of facilities (mainly hospitals) some contribution has been made to a

*In 1951 in the 10 states with lowest per capita income the ratio of physicians per 100,000 population was 83; in the 10 highest income states it was 135. There were sharp regional variations in the distribution of nonfederal physicians (from 164.1 per 100,000 civilian population in New England to 85.1 in the East South Central) and even sharper differences among states (from 287.3 in the District of Columbia or 185.3 in New York to 69.2 in Mississippi and 71.7 in Alabama). As Harris[20] (p. 161) shows, these relative scarcities were reflected in incomes; despite the lower per capita income in the Southeastern states general practitioners' incomes averaged higher (by $1510) than those of general practitioners in the wealthier Northeastern states, and full-time specialists in these poor states earned more than the U.S. average, indeed more than specialists in any region except the Northwest.[21]

better supply and, perhaps to a lesser degree, to distribution of personnel and facilities. But, as pointed out earlier, the role of philanthropy, in global terms, is not large.

Whatever the degree of success the private sector may have in ensuring an appropriate total supply of medical personnel and facilities, it has notably failed to ensure a geographically even distribution. In the case of physicians this reflects the freedom of the professional to locate in areas where he believes there is likely to be an effective demand for his services (i.e. one backed by an ability to pay) and, probably more importantly, in areas where there exist appropriate facilities (hospitals, laboratories, ancillary services, research centers) that will enable him to practice high-quality medicine. The professional seeks, too, the stimulus of a group of colleagues. This largely explains the relative scarcity of physicians in rural low-income areas and their high concentration in the metropolitan areas.[22] It is noteworthy that in these preferences medical men are not different from other professional groups who are motivated by the same desire to do work of high professional quality; the same type of maldistribution—giving rise to the same kind of social concern —is found among social workers and university professors.

The Role of Government

People have used their governments to overcome the problems of supply and distribution in various ways.

Supply of Public Funds to Encourage Training of Personnel and Construction of Facilities. Even in countries such as the United States, where government is not actively involved in the provision of medical care (other than to its own employees and a few special groups), this kind of action is found. The Hill-Burton Hospital Construction Act, the Mental Health legislation, the recently passed Nursing Act, all involving either construction and/or training grants are illustrations of this type of action—in this case by the offer of grants by the federal government to states and to nonprofit organizations. A similar quite comprehensive program was adopted in Canada in the National Health Grants Program of 1948.

In the United States this type of action has been especially noteworthy in regard to the production of knowledge and the training of research workers. The stimulus there has taken the form both of direct public operation (as in the various National Institutes of Health) and grants to

public and nonprofit organizations for research and training.

In a national health service such as the British, all initiative in the supply area is of course in the hands of government. On the one hand this approach has the advantage of ensuring a comprehensive evaluation of both total and relative needs (e.g. for different types of professionals or facilities, as well as geographical differentials) because "the government" is held responsible for inadequacies. The National Health Service (N.H.S.) in Britain, for example, has made noteworthy strides in grappling with the still serious shortage of nurses, although it has made less progress in regard to the shortage of dentists.

But sole public responsibility has also certain disadvantages, or social costs. Concentration of control of supply in the hands of a single authority means that a wrong decision can have serious consequences.*

To both the professions involved and to the government, centralization of responsibility for ensuring an adequate supply of personnel for the health services has the troublesome consequence of involving government in the determination of the terms and conditions of employment. For it is not merely a matter of attracting and retaining an appropriate total supply: the relative supplies of different kinds of professionals are also involved (general practitioners versus specialists, different types of specialists, etc.). The story of the negotiations of the British government with the various medical groups since 1948 indicates the complexity of these problems.[23] At the same time, it must be recognized that the problem of appropriate price relationships among various types of medical personnel has not always been satisfactorily solved when decisions are left to the private sector, and governmental decision-making has at least the advantage of bringing the issues into the open.

Finally, where the decision to allocate more or less of national resources to the health services is made centrally by government, the health services are necessarily evaluated in relation to other national needs. From the national standpoint this is, of course, desirable, but it may mean that at times the health services are accorded a lower priority than they might have secured if the decision to increase supply had been left to the private sector. The failure of the British for the first thirteen to fourteen years of the Health Service to construct any sig-

*The decision of the British government to cut by 10 per cent the entrants to medical schools, following the recommendations of the Willink Committee a few years ago, has proved to have been an unfortunate underestimate of total medical needs, and shortages are already developing.

nificant number of new hospitals is a case in point (the situation is now being remedied). And, in a country with powerful sectional or other organized pressure groups, governmental decisions as to the supply and, more particularly, the location, of facilities may reflect political pressure rather than rationally determined need (e.g. the supply and location of veterans hospitals in the United States).

Measures to Control the Geographical Maldistribution of Facilities and Personnel. Governments have sometimes dealt with the problem of acute shortage of personnel and facilities, especially in isolated areas, by direct employment of professionals and provision of facilities in these areas. Thus, in Sweden, where for geographical reasons this problem is acute, there has long been a system of salaried district medical officers who both oversee health conditions in their areas, provide direct medical care and, on occasion, direct small hospitals. In the western provinces of Canada isolated communities have formed hospital districts to erect and maintain hospitals out of public funds. In Saskatchewan the inability of isolated rural areas to attract private physicians led to the development of the municipal doctor system whereby a doctor is hired from public funds to provide general practitioner service, a system that considerably expanded after 1939 until it was replaced by the comprehensive Medical Care Program in 1962. To a lesser extent this system has also been used in Alberta and Manitoba.

Another approach available under social insurance or national health services has been to offer special inducements to doctors to practice in otherwise unpopular areas. These may take the form of higher remuneration and other privileges. But they may also take the form of efforts to meet the professional's dislike of the other conditions affecting his work, by constructing, or encouraging the construction of, medical facilities, or by promoting further training and contact with research-oriented colleagues by special leave programs and additional payments for educational leave.

A third technique for correcting the maldistribution of physicians has been adopted for general practitioner service in Great Britain and is known as "negative control." A doctor who desires to practice under the N.H.S. may not do so in an area that has been classified by a national Medical Practices Committee (seven of whose nine members are general practitioners) as "overdoctored" although he is free to practice anywhere he wishes as a private practitioner. The effectiveness

of this technique depends of course on the coverage of the public program and the importance attached by professionals to the privilege of being associated with it.

Where health services are directly operated by a government that both owns the facilities and directly employs the professionals, maldistribution can be directly dealt with by decisions as to the location of facilities and the size and composition of their staff. It is generally agreed, for example, that since 1948, the N.H.S. in Britain has brought about a considerable improvement in the distribution of specialists who, if operating under the Service, are employed on a salaried basis in the public hospitals.

It is indeed difficult to see how the problem of maldistribution can be resolved without the direct involvement of government. The resources of the thinly populated or poorer areas must be supplemented if they are to offer the remuneration and, more importantly, the other conditions of employment that appeal to professionals. And it is doubtful whether reliance on economic inducements alone will correct the situation.*

In Britain there has been little improvement in the geographical distribution of dentists, in contrast to that in the general practitioner and specialist services where some controls, as indicated above, have been applied.

Other Obstacles to Securing Appropriate High-Quality Care

Even where medical personnel and facilities abound and even where the consumer possesses an "adequate" income he cannot be sure that he is in fact obtaining appropriate and high-quality medical care. Unlike the consumer of automobiles, food, clothing, etc., the purchaser of medical care offered on the open market is often a poor judge of good or bad quality and of the appropriateness of one type of treatment or care versus another, while the consequences of a mistaken choice may be infinitely more serious. This is, of course, because such judgments call for training and technical knowledge not possessed by the nonprofessional. The plight of the consumer is intensified by the develop-

*Even in Sweden, where there is a very comprehensive public hospital system and a method of remunerating doctors that attempts to reflect geographical differences and types of responsibility, there is a heavy concentration of professionals in Stockholm. And in Norway, where the comprehensive insurance system pays doctors on a fee-for-service basis, the otherwise highly enthusiastic director general of Health Services has to admit that the system does not guarantee an equal distribution of doctors throughout the country, and that the problem is especially acute in regard to specialists.[24]

ment of specialization among the professionals and by the uncoordinated nature of current institutional arrangements for the supply of health services. Where dissatisfaction exists, the consumer is frustrated in many cases by the absence of any machinery for ventilating complaints and having power to remedy the situation.

The Role of the Private Sector

Some safeguards are, of course, provided in the private sector.

1) In any market where goods and services are supplied by private enterprise, control over quality and appropriateness is supposed to be assured by consumer preferences selecting among competing suppliers. In the provision of health services, however, this mechanism operates only to a limited degree. Even if the consumer has the knowledge to distinguish between "good" and "bad" care his control is severely limited.

First, difficulties are faced by the individual in changing his source of supply. If a patient is dissatisfied with his physician, what other one does he choose? Unlike sellers in the commodity market, suppliers of medical care do not advertise their wares and their good points (and by implication the bad points of competitors). Medical etiquette even denies the consumer the benefit of expert judgment of one professional by others—and also places psychological obstacles in the way of a change of physician.

Second, insofar as institutional services go, the consumer, at the time he needs such care, is scarcely in a position to exercise choice. In any case, here he faces the problem of joint supply. He uses those facilities that are available to the surgeon or physician who treats him. In many communities there is one only hospital or other facility.

Third, the final control exercised by the individual consumer lies in the possibility of bringing damage suits. These actions have increased markedly in recent years. But their usefulness as an instrument for assuring appropriate and high-quality care is questionable. The cost of bringing action is likely to deter many dissatisfied individuals. The outcome is uncertain, in part due to the professional solidarity of the suppliers of services. The growth of insurance against such actions on the part of professionals may yield sizeable damages to the aggrieved patient, but the deterrent effect upon the incompetent physician of the fear of a suit is likely to be weakened. Finally, fear of such suits, as

suggested below, may encourage overuse of certain medical resources.

It might have been expected that group action by consumers would have exercised control over appropriateness and quality. But this seems to have occurred only to a limited degree. Consumer information services, similar to those evaluating quality and price of other consumer items, do not exist except occasionally in regard to certain drugs. Organized purchasers of care and services, such as the nonprofit and commercial insurance companies, have in general refrained from involvement in the appropriateness and quality of service, although they are increasingly concerned about the quantity and cost of care.

The lack of involvement in appropriateness and quality on the part of the major organizations paying for care in the United States is probably not unrelated to the fact that they originated with suppliers of care or as a profit-making venture, and their management typically contains little or no consumer representation. Only in the consumer-organized or initiated programs, such as union-negotiated plans or some group-health plans, does the consumer have the power to evaluate and, possibly, to do something about, quality. Yet even in the union-negotiated plans, involvement with questions of quality and organization for the provision of health services has been limited.*

2) To a very considerable extent the private sector today relies on the medical profession to deal with problems of appropriateness and quality. The assumption is that the patient will select a general practitioner (who as a licensed physician presumably possesses some approved level of competence) who will normally refer the patient elsewhere for such services as he himself cannot provide. But this system has serious shortcomings.

First, the general practitioner may himself not be highly competent. He may indeed possess the minimum qualifications required for licensing at the time he was licensed. But with the rapid growth of medical knowledge the general practitioner of yesterday may not be qualified today. Those who have access to hospitals, especially teaching hospitals, are more likely to keep in touch with new developments, and certainly they have the advantage of available consultants. But this is not the case

*A small number of unions directly operate union health centers that may offer limited or extensive services. The United Auto Workers is the most noteworthy example of a consumer-oriented group endeavoring to grapple with problems of organization, but hitherto its success has been limited. The Somers' conclusion seems inescapable: "As of the present, it is clear that the medical consumers' new spokesman—the health and welfare plans—have been too contradictory and inconsistent to affect the organization of medical care to the extent that their numerical and financial strength might suggest." [25]

for the doctor in less well-equipped communities. In regard to the increasingly technical field of drugs, antibiotics, etc., the evidence suggests that to a large extent the physician is "educated" by representatives of the drug manufacturers supplemented by evaluations in the professional journals. The consumer can hardly feel that the first is likely to lead to the most effective prescriptions;[26] nor has his confidence in professional evaluations been reinforced by recent revelations. In any case, the average practitioner's work load is such that the time he can devote to professional study must be severely limited. (This may be another indication of the scarcity of doctors.)

Second, not every individual or family uses a "family physician." This is due in part to financial considerations, but it also seems likely to reflect some loss of confidence in the professional competence of the average general practitioner. To an increasing degree patients appear to make some of their own diagnoses and select their own specialists.

The medical profession is also entrusted by society with the policing of performance by its own members. There seems to be general agreement that where a large number of medical professionals function within the confines of a given institution this kind of "peer control" can be highly effective, although there are instances to the contrary. But this kind of control can hardly operate in sparsely-doctored areas and, in general, its effectiveness among solo-practicing general practitioners is probably limited.

There is, moreover, considerable evidence that the "ethics" or, at least, the "etiquette" of the profession serves to limit the extent to which it does indeed police itself. The extent of abuse by medical men in certain Workmen's Compensation systems, unchecked by the profession itself, is well known. The reluctance of doctors to testify against colleagues is understandable, but hardly conducive to enforcement of professional standards.

The Role of Government

Public action to ensure high quality and appropriateness has taken several forms.

Control of the Quality of Certain Types of Service or Supplies. Reference has already been made to the fact that where the welfare of the individual will be threatened by incompetent practice, governments typically require the practitioner to obtain a license to practice, which

is granted on the basis of a test of competence. The professionals applying the test may be directly employed by government or, more usually, responsibility is delegated to a recognized professional organization.

To a growing extent the same concern appears to be extending to institutions, although the control is not so rigid or so widespread.[27] Compliance with the standards of privately organized professional accrediting bodies may not be legally required as a condition of continued operation, but if government plays a large role in the organization or financing of health services it may be enforced *de facto*. Participation in, e.g., a health insurance system (of the King-Anderson Bill) may be limited to accredited hospitals or nursing homes. Public assistance authorities may reimburse the costs of medical care provided their clients only if supplied by an accredited institution.

Another type of control of quality is represented in this country by the Food, Drug and Cosmetic Act, and similar arrangements exist elsewhere.

Measures Affecting the Physician's Relationship to His Patients. Two elements entering into the concept of "quality of care" have always been of great concern to the medical profession when contemplating compulsory health insurance systems or national health services. They are the freedom of the patient to choose his doctor and the freedom of the doctor to treat his patient without third-party intervention.

In the democracies, all public programs that have wide coverage permit the patient to select his own general practitioner and to change if dissatisfied. This is obvious in such schemes as the Australian system of subsidizing private insurance, which interferes not at all with the traditional methods of operation of medical men and hospitals. But it occurs, too, in almost all compulsory insurance systems. Even though the patient may be required to use a doctor who has agreed to participate in the program,* the fact that in most such countries there is extensive participation gives the patient a wide measure of choice, probably far wider than would be available to those of low or modest income in the absence of compulsory insurance. In universal coverage systems or a national health service free choice is even more certainly ensured. Although doctors are free not to participate in the program, indirect pressure from patients ensures that most of them do.

*For some countries using the reimbursement system the patient is permitted to use professionals or institutions other than those entering into agreements with the government, but he is reimbursed only up to, or occasionally below, the legal tariff.

The major areas in which government's concern with costs has involved any interference with the doctor-patient relationship are the use of drugs and of hospitals. All the evidence suggests that in general public authorities are almost excessively careful not to interfere in the direct patient-doctor relationship and that frequently they confine themselves to admonition, to advisory circulars, and to public reports. Even where more direct controls are applied the public administrators have attempted to operate through professional organizations or channels. Thus in Great Britain, when administrative records indicate that certain doctors are grossly out-of-line in regard to the volume of prescriptions, disciplinary action is taken by the local Executive Councils, which consist primarily of medical men. Similarly, suspected overuse of hospitals may be met by a requirement for the formation of a professionally staffed utilization committee in each hospital.

The desire to control unnecessary prescribing, or the use of expensive proprietary drugs in place of cheaper and equally efficient prescriptions, disciplinary action is taken by the local executive councils, publishing lists of drugs that can be freely prescribed, and listing others for which permission must be secured from some designated medically staffed committee. Some doctors regard this as an undue interference in their professional functioning.* Even where the pressure to control costs or the need to correct abuse or gross malpractice causes a public authority (e.g., the social insurance agency or the administrator of a national health service) to question the treatment given to an individual patient, the officials conducting the investigation are always medical men. In general, however, the evidence suggests that this type of supervision of an individual practitioner's judgment occurs primarily in relation to the certification of inability to work in the case of workers claiming disability insurance *cash* benefits, rather than in regard to the program concerned with provision of health services *per se*.

The Impact of Specific Financial Arrangements on Quality. Financial considerations and specific financial arrangements with suppliers of care can and have exerted an adverse effect on quality.

Unwillingness of the community to provide through the tax system total sums adequate to provide high-quality health services may lower

*In the Dental Service in Britain, which operates on a fee-for-service basis the more expensive and complicated operations (one fifth of the total) require the approval of a Dental Estimates Board, seven of whose nine members are dentists. Over the years the list of procedures requiring approval has been somewhat shortened, although not to the full extent desired by the British Dental Association.

quality in various ways. Failure to invest sufficient public funds to train and equip an adequate supply of professional personnel may lead to unduly long patient lists and perfunctory service. Failure to devote adequate resources to public hospitals (as happened in Great Britain until recently) means long waiting lists and crowded conditions—as it does in the city of New York.

Arrangements for the remuneration of practitioners can and have also affected quality. Failure to set levels of remuneration that in general compare favorably with those for professions or employments calling for comparable skills and training may cause the public service to face difficulty in attracting and retaining an appropriate supply of medical personnel. Differential levels of remuneration that place the specialist (as in Great Britain) at an advantage as compared with the general practitioner may drain personnel away from an essential service, although if (as also in Great Britain) government controls specialist appointment to hospitals, the grosser effects can be avoided. Where both public and private systems prevail, low levels of remuneration and unsatisfactory working conditions in public hospitals may result in a lowered quality of public hospital staffs.

Where fee-for-service systems operate, the relative payments for different medical acts or procedures may have an unintended adverse effect on quality or appropriateness of care. In Australia it is claimed that the fee schedule encourages excessive appendectomies and tonsillectomies. In Great Britain the original scales for dentists (who unlike specialists and general practitioners are paid on a fee-for-service basis) placed a premium on extractions to the disadvantage of preventive services.

But as against these risks governmental participation in, or operation of, health services has two important advantages over private arrangements, namely, visibility and the existence of an authority that can be held responsible for shortcomings and has power to take remedial action. This advantage is the greater the more nearly universal is the coverage of the public programs. The most impressive feature of the British experience since 1948 has been the extent to which shortcomings of the medical services as they affect the patient and the quality of care have been brought into the open and made the subject of public inquiry and remedial efforts.[28]

Under private arrangements for the supply and financing of health

services, many of these shortcomings exist but either they are not brought to light or may be concentrated on "the poor" and disregarded; or, if known, there is no authority in a position to take remedial action.

Governmental Influence on the Organization of the Health Services. With the exception of a country operating a national health service such as Great Britain, governments appear to have done relatively little to effect an orderly and convenient organization of services. This is probably due to three factors. First, short of compulsion or direct operation by government, it has not proved possible to ensure that all organized groups will subordinate their own interests in perpetuating the *status quo,* to conform to the requirements of some over-all national plan (especially when it might mean ceding some responsibilities to others or even, at the extreme, going out of business). Second, an over-all plan may well indicate the need for certain services or agencies that are unlikely to be made available except by direct public provision. Third, in some areas there does not appear to be any agreement among professionals as to the nature of the ideal organization. What, for example, should be the role of the general hospital in the total structure of health services? Is group (as opposed to solo) practice the ideal to be sought? And what is to be its nature? What ought to be the relationship of the general practitioner to the hospital? What, ideally, is the role and nature of "community health services," and what should be their relationship to hospitals on the one hand, and the general practitioner's services on the other? Here is another area where the nonmedical social planner lacks authoritative guidance from the health professions. (Perhaps the deficiency will in time be remedied by the current growing importance of schools of administrative medicine, or perhaps guidance can be given by an authoritative body such as The New York Academy of Medicine!)

Even Great Britain has not succeeded in resolving many of these organizational problems. The decision to nationalize the hospitals and to divide the country into hospital regions, each containing one or more teaching hospitals and each with a Regional Hospital Board responsible for planning an integrated series of institutions for its own region, for the preparation of budgets, and for the administration of the funds granted by the government, has indeed made possible a comprehensive and rational organization of hospital services (even though, as pointed out above, hospital construction has fallen short of indicated needs[29]).

Even here, the existence of a largely independently administered system of teaching hospitals has created some problems. But the decision (in deference to professional wishes and historial traditions) to organize, on separate bases, the general practitioner services (including dental and ophthalmic services) and certain health services (largely of a preventive character, but including also ambulance services, health visiting district nursing, home helps, domiciliary midwifery, and prenatal clinics), has created problems of coordination. The problems are likely to become more acute because Britain, too, has become increasingly committed to the doctrine of "getting the patient back into the community." It is far from clear whether all local authorities will be willing or able (even with subsidies from the central government) to develop all the needed community facilities and services. Nor, despite an earlier commitment, has any real progress been made in the development of local health centers to bring together, in one building, preventive, general practitioner, and certain diagnostic services. Financial restrictions and a growing loss of enthusiasm on the part of the medical profession for this type of organization appear largely to account for declining interest in the local health center and the substitution of measures to encourage group practice (such as governmental loans for buildings or office accommodation).

A more modest example of an effort by government to encourage the development of a more rational structure of health services is represented by the federal government's offer of grants-in-aid to encourage community assessment of needs and development of plans to meet them.* Occasionally the federal government itself carries out such planning activities, the most notable example probably being the creation of the Joint Commission on Mental Illness and Health in 1955 that issued an influential report in 1960.[30]

Problems Related to the Economical Use of Social Resources

The consumer as a member of a society in which resources are limited in relation to needs and wants has an interest in seeing that adequate health care is made available in a way that makes minimum demands on total economic resources. Unnecessary utilization of per-

*Thus the Hill-Burton program of subsidies for hospital construction required as a condition of eligibility that states prepare a plan of hospital needs. The Medical Facilities Survey and Construction Act of 1956 provides grants for, *inter alia*, surveying the needs for treatment centers, certain specialized hospitals, rehabilitation centers, and nursing homes. A series of Federal Mental Health Acts (the most recent of which deals specifically with mental retardation) provide funds to stimulate state (and sometimes community) assessment of, and planning for, needs in this area.

sonnel, health institutions, or supplies (such as drugs) means that a corresponding volume of resources is not available to meet other needs.

The Role of the Private Sector

The Consumer

In the normal competitive private enterprise market, control is exercised by individual income receivers who are presumed to buy in the cheapest market. They select from among competing producers those who are so efficient that they can offer their wares at minimum cost (i.e. they make minimum demands on available resources in order to produce what they have to sell).

For the provision of health services this kind of control is much less effective; indeed, current arrangements for the supply and financing of health services would seem rather to foster overuse of resources. The lack of technical knowledge on the part of the consumer, as in regard to quality, puts him at a disadvantage in knowing how much of any kind or type of treatment is absolutely essential (e.g., how many drugs, diagnostic tests, x rays, and the like, are necessary—how long a stay in hospital is indicated) for the efficient treatment of any complaint.

The limited extent of insurance covering outpatient, diagnostic, and other services to other than hospital inmates or the costs of care in institutions less economically costly than hospitals, such as nursing homes, chronic disease facilities, and the like, coupled with the sheer nonavailability of such less expensive institutions in many areas, tends inevitably to foster overuse of the facility for which insurance is available. Similarly, the lack of appropriately organized community services to continue necessary treatment of the discharged patient is generally agreed to result in longer (and costlier) hospital stays than are essential (though here a *caveat* should be interposed, for too little is known of the actual cost of a truly adequate supply of community-based medical and ancillary services needed to assist the patient and the family to whom he returns). Again, it has been held that the fear of damage suits (or high insurance rates) has encouraged the proliferation of diagnostic tests that cause so much complaint among consumers.

A further difficulty arises because the market for health services is not competitive. Generally, in the field of institutional care, facilities are not constructed in response to the prospects of profit, and suppliers

do not compete with each other on a price (i.e. efficiency) basis. Hospitals may be constructed or expanded because of civic pride or because of the availability of philanthropic funds. Excess bed capacity may be reflected in higher charges for occupied beds, but the consumer has no way of knowing how far the higher price is due to this factor or to other, more economically justified, costs. The efficiency of operation of, e.g., hospitals is not subject to the normal control of inefficiency, i.e. that the inefficient operator is driven out of business. Only recently, as organized purchasers of hospital services have begun to fear that hospital insurance may be "priced out of the market," have probing questions been raised about the economic operation of hospitals, and these have come from public officials evaluating proposed premium increases.

To the extent that overuse of resources is attributable to the behavior of consumers, organized sellers of insurance can exercise some control on rising quantity and cost by restricting the forms or duration of care against the costs of which they will insure or by introducing "deductibles" and "coinsurance." The former may, however, adversely affect total treatment while both limit the extent to which insurance helps the consumer with his financial problem.

The Medical Profession

Heavy reliance appears to be placed on the medical profession to control excessive utilization of scarce resources, but it is doubtful whether any profession, especially in the health services, can be expected to carry this responsibility.

First, the physician is subject to pressures from his patient that may be difficult to resist. Reference has already been made to the overuse of hospitals when hospitalization is the only way in which a patient can be reimbursed for some medical procedures. All systems, public and private, have encountered problems of overuse of pharmaceuticals, or of the use of more expensive proprietary drugs than is necessary. While part of this is undoubtedly attributable to the professional convenience of the doctor, no small part of it appears to stem from pressure from patients.

Second, all professions, including the medical, appear to suffer from a chronic occupational disease that takes two forms: 1) an unwillingness to recognize the fact that there are other claims on national resources, and that what is devoted to health services is taken away

from some other use; and 2) an overestimation of the degree of training essential to the proper performance of all "medical acts." The first results in an insistence on optimum conditions (equipment, premises, time allowances, etc.) believed favorable to what is currently regarded as high-quality practice. The second leads to a reluctance to relinquish to less highly trained workers certain types of services or procedures once the exclusive prerogative of the profession. Both lead to unnecessary use of resources to achieve a given result.

Third, all professions appear to be characterized by what I have elsewhere termed "professional myopia": they tend to diagnose all problems in terms of the kind of expertise they are uniquely equipped to provide. Yet some "health" or "medical" problems may require for their solution measures other than "medical treatment," and to continue to deal with them solely by calling for the services of more expensively trained medical personnel involves a waste of economic resources. Illustrations of this kind of myopia abound. The reluctance with which the medical profession accepted the psychic element in illness is one. The relative lack of involvement of the medical profession in efforts to secure better housing, or more adequate income for the poor—both of which have a direct bearing on the health of individuals —is another. And once again the parallel can be drawn with social work. As social workers have become more professionally self-conscious and have identified professionalism with an ability to improve the functioning of the individual they have tended to diagnose most social problems as calling for more social workers rather than for environmental change that might relieve the pressures on individuals and diminish the need for supportive services from social workers.

Fourth, avoidance of excessive use of economic resources requires the cooperation of many professional groups, of which the medical profession is only one, albeit the one most strategically placed.

The Role of Governments

Although, as previously stated, governments have tended to concentrate on the problem of the financial barrier to receipt of health services, and to avoid so far as possible involvement in the structure and organization of these services, they have inevitably been concerned with the effective use of resources as this reflects itself in the cost of the program.

For from this point of view public responsibility for financing part of or all health services has the overwhelming advantages of visibility and accountability. The costs are immediately apparent and, because they must be covered by taxation (or contributions in social insurance systems), the administrators must justify their budgets and defend the efficiency of their operations to the reluctant taxpayers.

Where, as in the British Health Service, government operates its own institutions, the pressures from taxpayers to keep costs down has led to a series of investigations into the efficiency of operation of hospitals, etc., and some notable reforms.[31] But the great advantage in terms of economizing resources, of the nationalization of hospitals both voluntary and those operated by local government, was the possibility offered, and taken, of restructuring the whole set of institutions so as to avoid wasteful deployment of resources. This was probably the one truly revolutionary feature of the British Health Service.

Short of power to compel reorganization (including the suppression of unneeded or overlapping facilities) the public health insurance administration can exercise only the powers of a large-scale buyer, although these may be considerable. In negotiating reimbursement terms with hospitals or other privately operated institutions it is in an especially good position to influence the efficiency of operation 1) because the business it has to confer is so large; 2) because it will have dealings with so many different institutions that comparative analyses can be made and concepts of "normal" costs can be developed; 3) because, as part of its accountability responsibilities, it can make public reports on the causes, as it sees them, of the high costs of the health service.

The existence of a large-scale consumer-oriented organization purchasing health services does not, of course, ensure that service will be rendered at minimum cost. But it introduces an element of "countervailing" power into a situation characterized by a high degree of monopoly on the part of sellers of service. In some cases the organization, as a large-scale user of supplies, may undertake direct production (e.g., of drugs) although the threat to do so is often sufficient to cause private producers to lower prices.

Where government is the buyer of limited services only, or of complete service for a limited group, its power to insist on economical operation of the institutions from which service is purchased is of course much less.

Insofar as wasteful use of resources is attributable to consumer misuse (excessive calls on physicians' time, overutilization of drugs, carelessness in the use of appliances), governments have made use of some of the same controls as are used by private insurance. Deductibles in the form of a requirement to make some minimum payment for prescriptions or appliances in service programs and coinsurance in the reimbursement systems are quite extensively used although, as pointed out earlier, the latter may create financial barriers to needed services.

The Challenge to the Medical Profession

The growing involvement of government in health services admittedly imposes new demands on the medical profession. For the experience of all countries demonstrates that the interests of the profession (whether in regard to remuneration, or conditions of employment and practice, or the provision of an institutional or organizational structure conducive to the rendering of high-quality service) are likely to be assured only when the profession itself participates actively in the program, over and above providing service for stipulated payments. It means involvement in both policy formation and administration. If professional competence is to be determined by professionals, some members of the profession must serve on practice or grievance committees, or on committees evaluating colleagues for salary increases. If the financial interests of the profession are to be protected adequately some professionals must devote time to serving on negotiating committees. There is, indeed, scarcely any aspect of the functioning of a comprehensive governmental program that does not call for the active participation of representatives of the health professions.

This would be a relatively new role for medical men in the United States, and it is one that makes special demands on its more distinguished members. More than any other factor it is the willingness or unwillingness of the profession to assume these new responsibilities that will determine whether or not the increasing role of government in the health services will result not only in wider availability but also in improved service.

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